STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	A. BUILDING COMPLETED			
			B. WIN		-	02/27/	2014
NAME OF B	DOLUDED OD GUDDU IED		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	<u>.</u>		7525 RG	OSEGATE DRIVE		
ROSEGA	TE COMMONS AS	SISTED LIVING		INDIAN	APOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R000000							
			D 0 0	0000			
			R00	0000			
	This visit was for	or a State Residential					
	Licensure Surv	ey. This visit					
	included the Inv	vestigation of					
	Complaint IN00)144899.					
	,						
	Complaint IN00)144899 -					
	•	No deficiencies					
		llegations are cited.					
	Telated to the a	negations are cited.					
	Survey dates: February 24, 25, 26,						
	-	-ebidary 24, 25, 26,					
	& 27, 2014.						
		. 040000					
	Facility number						
	Provider number						
	AIM number: N	N/A					
	_						
	Survey team:						
	Marcy Smith, R						
	Patti Allen, SW						
	(February 24, 2	25, & 27, 2014)					
	Dottie Plummei						
	(February 25, 2	•					
	, , , , , ,	, , ,					
	Census bed typ	oe:					
	Residential: 85						
	Total: 85	•					
	10tai. 00						
	Conque Daver	typo:					
	Census Payor f	ıyp e .					
	Other: 85						
	Total: 85						
	Residential san	nple: 9					
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	I	TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Page 1 of 14 State Form Event ID: G60K11 Facility ID: 012936 If continuation sheet

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/27/2014
ROSEGA	PROVIDER OR SUPPLIER	SISTED LIVING	7525 R INDIAN	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DRIVE JAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	cited in accorda	sidential findings are ance with 410 IAC completed on March			
R000297	410 IAC 16.2-5-6(Pharmaceutical So (c) If the facility co administers medic facility shall do the (1) Make arranger pharmaceutical se provide residents of medications in acc laws of Indiana. Based on interv review, the faci insulin as order for 1 of 2 reside diabetes in a sa #66) Findings includ The clinical rec was reviewed of	c)(1) ervices - Noncompliance introls, handles, and ations for a resident, the following for that resident: inents to ensure that ervices are available to with prescribed cordance with applicable view and record lity failed to obtain ed by the physician ents reviewed for ample of 9. (Resident e: ord of Resident #66 on 2/25/2014 at 4:15 is included, but were liabetes, ineuropathy,	R000297	It is the common practice of the facility to ensure that pharmaceutical services are available to provide residents prescribed medications in accordance with applicable late of Indiana. CORRECTIVE ACTIONS: Resident number #66 - physician notified that resident was discharged from hospital sliding scale orders that were transcribed to medication administration record by nurse Physician was also made away that resident was to receive insulin Lispro by sliding scale	with ws t with not e.

State Form Event ID: G60K11 Facility ID: 012936 If continuation sheet Page 2 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING	00	COMPLETED
			B. WING			02/27/2014
NAME OF D	DOMED OF CLIPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER		1 7	7525 RO	OSEGATE DRIVE	
ROSEGA	ATE COMMONS AS	SISTED LIVING	1	INDIAN	APOLIS, IN 46237	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	
TAG	`	LSC IDENTIFYING INFORMATION)		ΓAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE
	Resident #66 w	vas re-admitted to the			had not been given. At this tin	ne.
		2014, following a			physician gave new order to	-,
	•	sion for altered mental			discontinue all current sliding	
	-				scale orders and to discontinue	
		and dementia. The			all insulin orders (Humalog). N	
		nmary" indicated			order obtained from physician resident #66. Metformin 1000	for
		vas to start insulin			milligrams - one by mouth two	
		g), based on a sliding			times per day - and finger stick	
		ing scale indicated			for blood sugar twice per day	
		as to receive 1 unit			before meals.	
	of insulin lispro	for a blood sugar of				
	150-199, 2 units of insulin lispro for				IDENTIFYING OTHER	
	a blood sugar o	of 200-249, 3 units of			RESIDENTS HAVING	v=
	insulin lispro fo	r a blood sugar of			POTENTIAL AND CORRECT! ACTION TO BE TAKEN:	VE
	250-300, 4 unit	s of insulin lispro for			All residents on sliding scale h	ave
	a blood sugar o	of 301-349, 5 units of			the potential to be affected.	
	_	r a blood sugar of			Clinical director provided	
	•	units for a blood			in-service on 3/10/14 to all	
		han 400, and the			licensed nursing staff and	
	physician was				focused on residents returning with new medication orders.	1
	priyololari mao				Clinical Records have been	
	During a review	v of the "Capillary			audited by clinical director of	
	_	Monitoring Tool" for			residents receiving insulin.	
		a result of 163 mg/dl				
	· ·	iter) was documented			MEASURES PUT INTO PLAC	
	, ·	•			1) All new admitting orders will	l be
		t 7:00 a.m. Based on			reviewed by clinical director throughout the week	
		ed result, Resident			(Monday through Friday) once	
		re received 1 unit of			admission is completed by	
	•	s indicated by the			admitting nurse. If readmit or	
	•	er for sliding scale			new admission occurs on	
		was documented in			weekends, admission orders v	vill
	the column, "U				be reviewed by second nurse	ion
	,) Insulin [zero units			working during shift of admissi Clinical director will review the	I
	administered],"	for 2/24/2014.			following Monday to ensure	
					accuracy. 2) It will be evident	the
	A review, on 2/	24/14, of the			clinical director reviewed the	

State Form Event ID: G60K11 Facility ID: 012936 If continuation sheet Page 3 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII	DING	00	COMPL	ETED
			A. BUII			02/27/	2014
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
DOOFO	ATE COMMONIC AC	OCIOTED LIVINO			OSEGATE DRIVE		
RUSEGA	ATE COMMONS AS	SSISTED LIVING	INDIANAPOLIS, IN 46237				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	February 2014	medication			admission orders as the clinica	al	
	administration	record (MAR) for			director's signature will be loca	ated	
		ndicated Resident			at bottom of the medication		
		eive insulin lispro			administration record. 3) All		
		<u>-</u>			insulin orders will be reviewed		
	1	m., by sliding scale			and co-signed by two licensed nurses. No insulin orders can l		
	_	s were documented			transcribed without two license		
	1	at 9:00 a.m., and			nurses. 4) Both nurses reviewi		
		Documentation on the			orders will sign to indicate insu	-	
	MAR indicated	, "2/24/14, 9 AM			orders were reviewed by two		
	Humalog order	ed from Pharmakon."			licensed personnel. 5) Any		
	The MAR did not contain any initials				insulin written on medication		
	for Humalog on any other day in the				administration record will be		
	_	uary(February 21 - 23,			checked by two licensed nurse		
	2014).	24. y(1 05. daily 21 20,			and initials to indicate reviewe	d.	
	2014).				6) No insulin orders will be		
					discontinued without		
		view with the Clinical			validation/signature of two licensed nurses. 7) Any new		
		5/2014 at 10:45 a.m.,			medications from		
	the Clinical Dire	ector indicated, "The			admission/readmits when usin	a	
	staff should the	proughly review orders			Pharmakon, will be sent stat to	•	
	when the resid	ent goes out and			facility. Admitting nurse to		
	should clarify a	iny orders that have			document on 24 hour report ar	nd	
		new medications			inform oncoming nurse of new		
		ordered from the			medication status. 8) If		
		ne Clinical Director			medications are not received by	,	
	, '				time the admitting licensed nul		
		taff should have			leaves shift, oncoming nurse w		
		sulin lispro when			call Pharmakon to obtain statu of arrival of medications. If	5	
		eturned from the			medication not received in an	8	
	hospital on 1-2	1-2014, and the			hour period, staff to notify clini		
	pharmacy shou	uld have delivered the			director, family and physician.		
	medications wi	th the next scheduled					
		Clinical Director			CORRECTIVE ACTIONS:		
	1	dent #66 should have			Clinical director will review all		
		of insulin lispro on			admits/readmits within 24 hou	rs	
					of admission if occurs		
		0:00 a.m., as indicated			(Monday through Friday). Clin	ical	
	by the blood gl	ucose result of 163			director will review all		

State Form Event ID: G60K11 Facility ID: 012936 If continuation sheet Page 4 of 14

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/27/2014
	PROVIDER OR SUPPLIER ATE COMMONS ASSISTED LIVING	7525 R	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DRIVE IAPOLIS, IN 46237	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	mg/dl. The Clinical Director indicated the initials within a circle indicated the medication was not administered. During an interview with LPN #1 on 2/27/2014 at 10:15 a.m., LPN #1 indicated the insulin lispro for Resident #66 was stored in the refrigerator. LPN #1 retrieved a pharmacy bottle from the refrigerator. The bottle contained an unopened vial of insulin lispro. The label on the unopened vial of insulin lispro indicated the vial was filled on 2/24/2014, for Resident #66.		admits/readmits within 48-72 hours if admission occurs on weekend. Clinical director will review clinical charts for at lear months to ensure physician orders are being followed. WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED: Effective no later than 03/14/1	;

State Form Event ID: G60K11 Facility ID: 012936 If continuation sheet Page 5 of 14

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/27/2014
	ROVIDER OR SUPPLIER	SISTED LIVING	7525 F	ADDRESS, CITY, STATE, ZIP CODE ROSEGATE DRIVE NAPOLIS, IN 46237	133113
(X4) ID PREFIX TAG	(EACH DEFICIEN	CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
R000298	(2) A consultant ple employed, or under (A) be responsible in 856 IAC 1-7; (B) review the drug practices in the face (C) provide consult procedures of order administering, and well as medication (D) report, in writing his or her designed dispensing or admit (E) review the drug receiving these serview, and interestive failed to ensure substances were verified, according policy, for 2 of 2 controlled substances were verification. (LF) Findings included 1. During an object of the process of the policy for 2 of 2 controlled substances were verification. (LF) Findings included 1. During an object of the process of the policy for 2 of 2 controlled substances were policy. (LF) Findings included 1. During an object of the process of the pr	ervices - Deficiency narmacist shall be or contract, and shall: for the duties as specified a handling and storage cility; tation on methods and ering, storing, disposing of drugs as record keeping; g, to the administrator or eany irregularities in inistration of drugs; and gregimen of each resident roices at least once every revation, record erview, the facility controlled re counted and ing to the facility cobservations of tance counting and PN #1 and LPN #2) e: servation on 2/24/14 PN (Licensed) #1 was standing in	R000298	It is the common practice of the facility to ensure that controlle substances were counted and verified according to applicable laws of Indiana and facility's policy. CORRECTIVE ACTIONS: Narcotic counts are being completed on each unit per policy. IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL AND CORRECTI ACTION TO BE TAKEN: All residents that are receiving narcotics have the potential of being affected. Clinical Direct provided educational inservice all licensed nurses on 3/10/14 MEASURES:	de VE

State Form Event ID: G60K11 Facility ID: 012936 If continuation sheet Page 6 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) E			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED
			B. WIN			02/27/2014
		L	B. WII		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEI	₹			OSEGATE DRIVE	
DOSEC/	ATE COMMONS AS	SCISTED LIVING			IAPOLIS, IN 46237	
RUSEGA	ATE COMMONS AS	5313 TED LIVING		INDIAN	IAPOLIS, IN 40237	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	going off shift v	would co-sign the			1) A copy of the narcotic coun	
	count, verifying	the count was			policy/procedure was reviewe	d
		#3 came out of the			with licensed nursing staff on	
		at 2:08 p.m., and			02/24/14 by clinical director. A	.ll
		vas the nurse who			nursing staff verbalized their	
		nedication cart #2			understanding of the policy/procedure and clearly	
					understand they must count a	
	, ,	shift and would be			narcotics with two licensed	
		would verify LPN #1's			nurses present at all times. 2)	
	controlled subs	stance count for this			Licensed nursing staff must no	
	cart. She indic	cated, at that time, she			leave the medication cart whe	
	she didn't know LPN #1 had started the controlled substance count. She				count is taking place. 3) After	all
					narcotics are counted and	
		should have told me."			determined to be correct, both	
	maioatoa, mo	onodia navo tola mo.			nurses will sign and date narc	
	2 During chas	nuction on 2/24/14 of			count sheet. 4) Clinical directo	
	_	rvation on 2/24/14 at			will perform audits for 6 month	IS.
	· ·	I #2 was standing in			CORRECTIVE ACTIONS:	
		ition cart 1. She			Immediately notified staff on d	utv
	appeared to be	e counting controlled			and provided a copy and	aty
	substances/me	edications by herself.			reviewed the policy/procedure	for
	During an inter	view with LPN #2 on			narcotic counts. The clinical	
	2/25/14 at 4:10	p.m., she indicated			director met with all licensed	
		as counting with her			nursing staff. Clinical director	will
	on 2/24/14 at 2	_			perform audits for 6 months for	r
		ses were always			narcotic count to ensure	
		•			policy/procedure is being	
		ount the controlled			followed. After performing wee	
	substances at	shift change.			random audits, clinical directo will provide signature at bottor	
					narcotic count sheet.	11 01
	During an inter	view with the Clinical			narootto court sneet.	
	Director on 2/2	4/14 at 3:50 p.m., she			WHAT DATE THE SYSTEMIC	:
	indicated there	should always be 2			CHANGES WILL BE	
		g the controlled			COMPLETED:	
		each shift change.			All staff educated and practice	es
	Substances at	caon shint change.			put into place effective 03/14/	
	Λ f ooilite ! :	. data d 1/10				
		, dated 1/10, received				
	trom the Clinic	al Director on 2/24/14				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/18/2014 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A DIVIDENCE 00			ETED	
			A. BUII			02/27/2014	
			B. WIN		DDDEGG CITY OT TE ZID CODE	J	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ROSEGA	TE COMMONS AS	SISTED LIVING	7525 ROSEGATE DRIVE INDIANAPOLIS, IN 46237				
(X4) ID		FATEMENT OF DEFICIENCIES		ID	-,		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	at 2:40 p.m., titl	<u> </u>					
		ndicated, "3. In					
	-	Medication Sheet and					
		Narcotic sheet, the					
		rolled substances on					
		counted and verified					
	at the end of ea						
		n Sheet must be					
	•	e end of each shift					
	•						
every day. The outgoing Nurse or her designee will count all controlled							
	•	ng stored at the					
	community/faci	_					
	oncoming nurse	•					
	designee watch						
	•	that the count and					
		e been completed."					
	verincation hav	e been completed.					
R000306	410 IAC 16.2-5-6(g)(1-9)					
		ervices - Noncompliance					
	(0)	Iministered by the facility					
	shall be disposed	in compliance with il, state, and local laws,					
		any released, returned, or					
	•	tion shall be documented					
		clinical record and shall					
	include the following						
	(1) The name of the	ne resident. strength of the drug.					
	(3) The flame and (3) The prescriptio						
	(4) The reason for						
	(5) The amount dis	sposed of.					
	(6) The method of						
	(7) The date of the						
	the disposal of the	of the person conducting					
		of a witness, if any, to the					
	disposal of the dru						

State Form Event ID: G60K11 Facility ID: 012936 If continuation sheet Page 8 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
			B. WIN	G		02/27/2014	
NAME OF I	PROVIDER OR SUPPLIER)	•	STREET.	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	FROVIDER OR SUPPLIER	Λ		7525 R	OSEGATE DRIVE		
ROSEGA	ATE COMMONS AS	SSISTED LIVING		INDIAN	IAPOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG		5.112	
	Based on reco		R00	00306	It is the common practice of the		
	-	acility failed to ensure			facility to ensure disposition o medications was done accord		
	disposition of n	nedications was done			to facility policy.	mig	
	according to fa	cility policy for 2 of 2			is seems, person,		
	residents revie	wed for disposition of			CORRECTIVE ACTION #88 -		
	medications. (F	Resident #89 and			#89:		
	#88)				Resident #88 and #89 no long reside in facility.	ger	
	Findings include	le:					
					IDENTIFYING OTHER		
	The closed clinical record of Resident #89 was reviewed on				RESIDENTS HAVING		
					POTENTIAL AND CORRECT	IVE	
	2/26/14 at 9:20 a.m. Diagnoses				ACTION TO BE TAKEN:		
		vere not limited to,			All residents discharging from		
		ssure, hypothyroidism,			facility have the potential to be affected. Clinical Director		
	and gastroeso	• • •			in-service licensed nursing sta	aff	
	disease.	onagoai ronax			on 3/11/14. Clinical director to		
	discuse.				implement checklists, for licer	nsed	
	Pecident #80 r	passed away on			nurses, to follow upon dischar		
	11/5/13.	bassed away on			of resident. Checklist will incl		
	11/3/13.				instructions related to releasir medications to family and	ig	
	Dhygician and	ared medications for			returning medications to		
		red medications for			pharmacy or destruction of		
	· ·	current at the time of			medication.		
		uded, but were not					
		eprazole 20 mg			MEASURES:		
	, ,	gastroesophageal			1) Nurses in-serviced on	n of	
	1	roid 50 micrograms			policy/procedure on disposition medication and copy of policy		
	, , ,	lism, and metoprolol			provided to each licensed nur		
	25 mg for high	blood pressure.			2) Nurses verbalized the		
					understanding of disposition of	of	
	There was no	documentation in			medication policy. 3) Education		
	Resident #89's	record, which			binder had been placed in nul	rsing	
	indicated the d	isposition of these			station and is available as a	:-	
	medications af	•			resource to nurses. Included this educational binder is the	III	
					disposition policy/procedure a	nd a	

State Form Event ID: G60K11 Facility ID: 012936 If continuation sheet Page 9 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPL	ETED
			B. WIN			02/27/	2014
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			OSEGATE DRIVE		
DOSEG/	ATE COMMONS AS	SSISTED LIVING			APOLIS, IN 46237		
RUSEGA	ATE COMMONS AS	SSISTED LIVING		INDIAN	APOLIS, IN 40237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	2. The closed	clinical record of			discharge checklist.		
	Resident #88 v	vas reviewed on					
	2/26/14 at 8:45	a.m. Diagnoses for			CORRECTIVE		
		ncluded, but were not			ACTIONS/MONITORING:	1	
		blood pressure,			 After discharge of a residen the clinical director will review 		
	_	/ disease, dementia,			clinical chart within 48-72 hour		
	arthritis, and tr				for at least 6 months to ensure	-	
	arumus, and u	ciliuis.			disposition of medications wer		
	D : 1 1 1/00	P 1 1 1 1			done properly. 2) Discharge		
		vas discharged to			checklist copy to be given to		
	another facility	on 11/30/13.			clinical director from nursing s		
					for review. Prior to the release	e of	
	Physician orde	red medications for			medications the nurses will		
	Resident #88,	current at the time of			obtain a physician's order to include a list of all medications		
	his discharge in	ncluded, but were not			released and quantity provided		
	limited to, Tyle				will be documented on the	u	
		ardura 2 mg., Prilosec			medication release form. The		
	, ,	75 mg., Zocor 20 mg.,			order, along with the medication	on	
	_				release form will become a pa		
	•	0.5 mg., aspirin 81			the clinical record.		
	•	25-100 mg., and					
	hydralazine 25	mg.			COMPLETION DATE:		
					All staff educated and practice	es .	
	A nurse's note	, dated 11/30/13 at			put into place immediately effective 03/14/14.		
	3:00 p.m., indic	cated Resident #88's			enective 03/14/14.		
	daughter had,	"picked up all					
		The record did not					
	indicate which						
		ere given to the					
		nysician's order was					
		e resident's record,					
		•					
	which indicated						
		ould be released to his					
	daughter.						
	During an inter	view with the Clinical					
	Director, on 2/2	26/14 at 11:10 a.m.,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	COMPLETED		
NAME OF PROVIDER OR SUPPLIER ROSEGATE COMMONS ASSISTED LIVING	7525 R	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DRIVE IAPOLIS, IN 46237	•	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
she indicated there was no record of the dispensation of medications for Residents #89 and #88 after they left the facility, except for the note in Resident #88's record, which indicated the resident's daughter had picked up the medications. A facility policy, dated 7/2011, received from the Administrator on 2/27/14 at 10:55 a.m., titled, "Disposition of Medications when a Resident is Discharged from the Facility," indicated, "A medication may be releasedupon discharge only with a physician's order specifying which medications are to be releasedThe nurse will document in the clinical record and/or the 'Medication Release form.' "				
R000352 410 IAC 16.2-5-8.1(e)(1-4) Clinical Records - Noncompliance (e) The clinical record must contain the following: (1) Sufficient information to identify the resident. (2) A record of the resident 's evaluations. (3) Services provided. (4) Progress notes.	D000255	It is the common was time (a)	nis 03/14/2014	
received from the Administrator on 2/27/14 at 10:55 a.m., titled, "Disposition of Medications when a Resident is Discharged from the Facility," indicated, "A medication may be releasedupon discharge only with a physician's order specifying which medications are to be releasedThe nurse will document in the clinical record and/or the 'Medication Release form.' " R000352 410 IAC 16.2-5-8.1(e)(1-4) Clinical Records - Noncompliance (e) The clinical record must contain the following: (1) Sufficient information to identify the resident. (2) A record of the resident 's evaluations. (3) Services provided.	R000352	It is the common practice of the	nis	

State Form Event ID: G60K11 Facility ID: 012936 If continuation sheet Page 11 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED		
			A. BUII B. WIN			02/27/2	2014	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIEF	₹			OSEGATE DRIVE			
DOSEG/	ATE COMMONS AS	SSISTED LIVING			APOLIS, IN 46237			
RUSEGA	TE COMMONS AS	SSISTED LIVING		INDIAN	AFOLIS, IN 40231			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	CH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE		
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	review, the fac	•			facility to document and record	¹		
	document the i	results of blood			blood glucose in the clinical record.			
	glucose monito	oring ordered by the			record.	cora.		
	physician, for 1	l of 2 residents			CORRECTIVE ACTION:			
	reviewed for di	abetes in a sample of			Resident number #66 -			
	9. (Resident#	66)			physician notified that resident	t		
	•	,			was discharged from hospital			
	Findings includ	le·			glucose monitoring scheduled			
	l mamige morae				three times daily and order had	d		
	The clinical rec	ord of Resident #66			not been transcribed or performed by the licensed nurs			
	The clinical record of Resident #66 was reviewed on 2/25/2014 at 4:15				At this time, physician gave ne			
					order to discontinue all previou			
		es included, but were			blood sugar orders. New orde			
	not limited to, o				obtained from physician for			
	hypertension, r				resident #66 indicating finger			
	depression, an	d dementia.			sticks for blood sugar twice pe			
					day before meals (breakfast a	nd		
	Resident #66 v	vas re-admitted to the			dinner).			
	facility on 1/21	/2014, following a			IDENTIFYING OTHER			
	hospital admis	sion for altered mental			RESIDENTS HAVING			
	status, seizure	, and dementia. The			POTENTIAL AND CORRECTI	VE		
		nmary" indicated			ACTION TO BE TAKEN:			
		vas to start insulin			All residents on insulin have th	ne		
		og), based on a sliding			potential to be affected. Clinica			
	scale.	29/, 24334 311 4 3114111g			director provided in-service on	1		
	- Jours.				3/10/14 to all licensed nursing staff and focused on residents			
	Docidont #66 v	vas seen in the			returning with new medication			
					orders and insulin. Clinical			
	, ,	om on 2/6/2014. The			Records have been audited by	,		
		nmary" indicated			clinical director of residents			
	Resident #66 h	_			receiving insulin.			
	including, but r					_		
	"ALTERED AV	•			MEASURES PUT INTO PLAC			
	TRANSIENT, a	and UTI (Lower			1) All new admitting orders will	ı pe		
	Urinary Tract In	nfection)." The "After			reviewed by clinical director throughout the week (Monday			
	Visit Summary	" indicated Resident			through Friday) for at least 6			
	-	Continue These			months, once admission is			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	ER:		00	COMPLETED		
			A. BUILDING B. WING			2014		
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	ROVIDER OR SUPPLIEF	₹						
DOCECA	TE COMMONE AC	COLOTED LIVINIC	7525 ROSEGATE DRIVE					
RUSEGA	TE COMMONS AS	SSISTED LIVING		INDIAN	APOLIS, IN 46237			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE	
	Medications Which Have Not				completed by admitting nurse.			
	Changedinsulin lispro (Humalog)				readmit or new admission occi	urs		
	100 unit/ml [milliliter], inject into skin			on weekend, new admissions				
	3 (Three) times daily as needed Per			ordered will be reviewed by				
	,			second licensed nurse working				
	sliding scale" The physician's			during shift of admission. Clinical director will review the following				
	order on 2/6/2014 indicated				48-72 hours to ensure accurac	-		
	Resident #66 was to have glucose				2) Admitting nurse will create	· J ·		
	monitoring 3 times a day.				corresponding accu-check log			
					that will consist of the time			
	A review of the	"Capillary Blood			accu-check was completed, va	alue		
	Glucose Monitoring Tool" for Resident #66 for the month of				obtained and licensed nurse's			
					signature. 3) All documentation	n		
	February 2014, indicated Resident				to be maintained within the			
	•				clinical record. 4) It will be evid			
	#66 should have "Accucheck qd				the clinical director reviewed the	_		
	[every day], and prn [as needed]." The documentation indicated the blood glucose was checked once				admission orders as evidence second signature at bottom of			
				medication administration re				
					modication administration record.			
	daily at 7:00 a.	m., 2/1/2014 through			CORRECTIVE ACTIONS:			
	2/26/2014.				Clinical director will review all			
					admits/readmits within 24 hour	rs		
	During an inter	view with the Clinical			of admission if occurs			
	Director on 2/25/2014 at 10:45 a.m.,				(Monday through Friday). Clin	ical		
		ector indicated, "The			director will review all			
		·			admits/readmits within 48-72			
		proughly review orders			hours if admission occurs on			
		ent goes out and			weekend. Clinical director will review clinical charts for at lea	ct 6		
	_	iny orders that have			months to ensure physician	51.0		
	changed. Any new medications				orders are being followed.			
	should then be ordered from the pharmacy." The Clinical Director							
					WHAT DATE THE SYSTEMIC			
	indicated Resident #66 should have received blood glucose monitoring 3 times a day, as indicated by the physician's order 2/6/2014.				CHANGES WILL BE			
					COMPLETED:			
					Effective no later than 03/14/1	4.		
	pnysician's ord	EI Z/0/ZU14.						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00						
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7525 ROSEGATE DRIVE							
ROSEGA	TE COMMONS AS	SSISTED LIVING	INDIANAPOLIS, IN 46237							
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE				

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